110 Liberty Street
Brockton, MA 02301
855-60-SPORT(77678)
www.MySignatureCare.org

Athletic Training - Medical Consent / Authorization for Release of Information

Athlete's Name:_____ **Sport(s)**_____
PLEASE PRINT

School Name:_____ **Date of Birth (mm/dd/yyyy)** ____/_____/_____

Address:_____ **Cell Phone #: (**_____**)** _____

Emergency Contact Name:_____ **Relationship:** _____

Emergency Contact Cell Phone #:(_____**)** _____

I, on behalf of myself or as the parent or legal guardian of the above named athlete (if athlete is under 18 years of age), hereby give my consent to Signature Healthcare (an entity which includes Brockton Hospital and Signature Medical Group) and its healthcare providers and athletic trainers to provide sports medicine services to the Athlete as part of his/her participation in school's athletic program. The sports medicine services provided may include, but are not limited to: screenings, physical exams, and athletic trainer services. I grant permission to Signature Healthcare's providers and athletic trainers to provide such services to Athlete as deemed necessary for such providers and athletic trainers for any athletic injury treatment or prevention. I further grant permission for Signature Healthcare's providers and/or athletic trainers to treat Athlete for any injury or condition that arises out of Athlete's participation in the school's athletic program.

I understand that the services provided by Signature Healthcare's providers and/or athletic trainers relate to sports medicine services and are not intended to be a complete medical examination. I understand that the above named school's athletic programs are, by their very nature, capable of causing injury to the Athlete.

I hereby release Signature Healthcare and it's providers and athletic trainers from any and all liability associated with the care, treatment, examination or other sports medicine services provided to Athlete as part of Athlete's participation in the School's athletic program(s).

_____
Relationship (unless parent please attach copy of Documentation of authority, i.e. court order designating Guardianship)

_____
Signature of Parent. or Personal Representative or Guardian (if Athlete is under 18 years old)

_____
Signature of Student Athlete

_____
Date

I authorize Signature Healthcare's providers and/or athletic trainers to use or disclose Athlete's Protected Health Information to the following: the School and any individual involved in the operation of the School's athletic program(s), including without limitation athletic trainers, coaches, referees and athletic directors.

I authorize Signature Healthcare's providers and athletic trainers to use or disclose Protected Health Information for the following purposes:

To inform the above-named individuals of sports injuries sustained by Athlete

To inform the above-named individuals of other medical conditions that could affect Athlete's participation in School's sports program(s)

I understand that:

1. The Protected Health Information used or disclosed under this authorization may be subject to redisclosure by the receiver and no longer protected by confidentiality or privacy laws.
2. Authorizing the disclosure of this information is voluntary and is not required for treatment or payment purposes.
3. I can revoke this authorization at any time by writing to:

   Signature Healthcare
   Attn: SportSmart Program
   110 Liberty Street
   Brockton, MA 02301
4. I specifically authorize the disclosure of information regarding substance abuse, mental health treatment or reproductive health.

This authorization will expire when Athlete no longer participates in School's athletic program(s).

_____

Relationship (unless parent please attach copy of Documentation of authority, i.e. court order designating Guardianship)

_____

Signature of Parent. or Personal Representative or Guardian (if Athlete is under 18 years old)

_____

Signature of Student Athlete

_____

Date